Special Serologies: *To order one of these tests, mark "other serology" on reverse side and write in test name.*

Test:	Acceptable Specimen:
Candidiasis	Serum, 2 mL or Clotted Blood, 5-8 mL
Cryptococcosis	Serum, 2 mL or Clotted Blood, 5-8n mL or CSF, 1-2 mL
Hepatitis A IgM (Prior approval by the Division of Epidemiology required.)	Please call the Serology Section for instructions (502/ 564-4446).
Hepatitis C (Prior approval by the Division of Epidemiology required.)	Please call the Serology Section for instructions (502/ 564-4446).
Leptospirosis	Sera, 2 mL each; Acute and Convalescent
Rubella IgM (Prior approval by the Division of Epidemiology required.)	Please call the Serology Section for instructions (502/ 564-4446).
Sporotrichosis	Serum, 2 mL or Clotted Blood, 5-8 mL
Trichinosis	Serum, 2 mL or Clotted Blood, 5-8 mL

Note:
Hepatitis B testing of local heath department patients other than prenatal patients and their contacts must be approved by the Division of Epidemiology prior to testing. Hepatitis B testing of local health department employees other than for determining immune status following immunization and in managing needlestick situations must also be approved by the Division of Epidemiology prior to testing.

Form 213
Revised 12/17/2004

"This form, when filled in, contains patient information that must be protected in accordance with the Health Insurance Portability & Accountability Act."

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019
William D. Hacker, M.D., Acting Director

Please complete a separate form for each specimen.
Yellow copy may be retained by the submitter.

Serodiagnosis

A double sided test order form

PATIENT INFORMATION:

Name (Last, First, MI) _____

Social Security # _____ Sex _____ Race _____ Age _____ Birthdate _____

Home Address _____

City _____ State _____ Zip Code _____ County _____

Send Report To:

Submitter _____

Street Address (PO BOX) _____

City _____ State _____ Zip Code _____

Please Use "L" Label or Fill in Completley

Specimen Information:
Date of Collection _____
Specimen type: ☐ Serum ☐ Whole Blood ☐ CSF ☐ Other_____

Purpose of Examination:

☐ Diagnostic
☐ Recheck Specimen
☐ Treatment follow-up
☐ Pre-Hepatitis vaccine
☐ Post-Hepatitis vaccine
☐ Needlestick Injury
☐ Immune Status
☐ Prenatal _____ weeks pregnant
☐ Other, specify _____

Routine Examination Requested:

☐ Rubella IgG
☐ Syphilis testing

Hepatitis B (See note on reverse side)

☐ HBsAg (Surface Antigen)
☐ Anti-HBs (Antibody to HBsAg)
☐ Anti-HBc (Antibody to HB Core Antigen)

Special Examinations

☐ Other Serology, Specify _____

Laboratory Findings: